



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

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TRENTON, NJ 08625-0715

JON S. CORZINE
Governor

www.nj.gov/health

HEATHER HOWARD
Commissioner

We are writing to you regarding your Pharmaceutical Assistance to the Aged and Disabled (PAAD) prescription coverage and your Medicare Part D prescription drug benefits. As a PAAD beneficiary who has Medicare, you must be enrolled in a Medicare Part D prescription drug plan in order to use your PAAD benefits. PAAD and Medicare Part D benefits work together to provide you with affordable, comprehensive prescription coverage. **Please read this entire letter carefully as it requires you to take action. You will need to make a decision about your Medicare Part D prescription drug plan and let the PAAD program know of your decision.**

According to PAAD records, you are currently enrolled in [CURRENT_PDP] for your Medicare Part D benefits. Please know that this plan is not one of the basic or standard Medicare Part D prescription drug plans in New Jersey with which the PAAD program is coordinating benefits. That means it is not a plan for which PAAD pays the monthly premium on behalf of its beneficiaries.

You have the following options regarding your Medicare Part D benefits as a PAAD beneficiary:

1. You may choose to remain enrolled in [CURRENT_PDP] in 2009. If you choose this option, you will be responsible for paying the entire monthly premium yourself directly to this plan. PAAD cannot pay the premium on your behalf as a PAAD beneficiary.

If you must remain enrolled in [CURRENT_PDP] in 2009 because your or your spouse's former employer or union requires you to be in this plan, please let the PAAD program know. PAAD will not be able to pay the premium for [CURRENT_PDP] on your behalf, but we will not enroll you in another Medicare Part prescription drug plan. Please provide a copy of the letter or notice from your or your spouse's former employer or union stating that you must be enrolled in [CURRENT_PDP]; or

2. You may move to a basic or standard Medicare Part D prescription drug plan for which the PAAD program does pay the monthly premium on your behalf. Based on the current drugs you use and the pharmacy you use, PAAD has determined that [NEW_PDP] appears to meet your prescription drug needs. If you choose this option, the PAAD program will facilitate your move into [NEW_PDP], and you will pay no more than

your regular PAAD co-payment of \$6 for generic drugs or \$7 for brand name drugs. In addition, if you choose this option, [NEW_PDP] would directly send you a new membership card, which would become effective January 1, 2009. You would use your current [CURRENT_PDP] card through December 31, 2008. Then when you receive the new Medicare Part D membership card from [NEW_PDP], you would show it along with your PAAD card at the pharmacy in 2009. If you choose this option and are billed directly for premiums by the basic or standard Medicare Part D plan, please call PAAD immediately at **1-800-792-9745** and ask for the COB Unit so we may work with you to correct this situation.

Please let the PAAD program know which option you have chosen by completing the information below and mailing it back to PAAD in the enclosed envelope by [REPLY_DATE].

Your full name:
Your telephone number:
Your Medicare Identification Number:
Your PAAD Identification Number:

Check v Only One:

<input type="checkbox"/>	<p>I choose to remain enrolled in [CURRENT_PDP] in 2009. By choosing this option, I understand I will be responsible for paying the entire monthly premium myself directly to this plan. PAAD cannot pay the premium in 2009 on my behalf as a PAAD beneficiary to [CURRENT_PDP].</p>
<input type="checkbox"/>	<p>I must remain enrolled in [CURRENT_PDP] in 2009 because my or my spouse's former employer or union requires me to be in this plan. I understand I will be responsible for paying the entire monthly premium myself directly to this plan. PAAD cannot pay the premium in 2009 on my behalf as a PAAD beneficiary for [CURRENT_PDP]. Enclosed is the letter or notice from my former employer or union stating I must be in [CURRENT_PDP].</p>
<input type="checkbox"/>	<p>I choose to have PAAD enroll me in [NEW_PDP] for 2009. By choosing this option, I understand PAAD will pay the monthly premium to [NEW_PDP] on my behalf for 2009. I also understand that [NEW_PDP] will directly send me a new membership card, which will become effective January 1, 2009. I will use my current [CURRENT_PDP] card through December 31, 2008. When I receive the new Medicare Part D membership card from [NEW_PDP], I will show it along with my PAAD card at the pharmacy in 2009.</p>

Thank you for your cooperation. If you have any questions, please call the toll-free **PAAD Hotline 1-800-792-9745** and ask for the COB Unit.

Sincerely,

The PAAD Program

Enclosure